Task Force Meeting 2

Monday, January 25, 2016 - 1 p.m. to 4 p.m.
Virtual Conference via Webinar

Welcome, Overview and Introductions

Collective Impact, the contracted facilitation team, provided the welcome, overview and introductions. Due to inclement weather, a webinar was deemed to be the best meeting alternative to an in-person meeting. Participants were asked to be patient and courteous during the session. A roll call of participants was taken with the following Task Force members being present:

- Doug Bentz – Roane General Hospital
- Hoyt Burdick, M.D. – Cabell Huntington Hospital
- Sharon Carte – WV Children's Health Insurance Program
- Ted Cheatham – WV Public Employees Insurance Agency
- Sarah Chouinard, M.D. – Community Care of WV
- Christopher Colenda, M.D. – West Virginia United Health System
- Mitch Collins – UniCare
- Fred Earley – Highmark Blue Cross Blue Shield of WV
- Michelle Foster, Ph.D. – Kanawha Institute for Social Research & Action
- Terri Giles – West Virginians for Affordable Health Care
- Tara Hulsey, Ph.D. – West Virginia University School of Nursing
- Dana King, M.D. – West Virginia University School of Medicine
- Eric Schmitz – Humana
- Eugenie Taylor – WV Chamber of Commerce
- Kim Tieman – Claude Worthington Benedum Foundation
- Todd White – CoventryCares of WV
- Robert Whitler – CAMC and Partners In Health Network
- Karen Yost – Prestera Center

Additional participants present on the call included:

- Joshua Austin – SIM Project Management Team
- Jon Cain – WV DHHR
- David Campbell – SIM Project Management Team
- Jeffery Coben, M.D. – SIM Project Management Team
- Arnie Hassen, Ph.D. – SIM Project Management Team
- Dennis Weaver, M.D. – The Advisory Board
- Courtney Newhouse – SIM Project Management Team
- Tom Gilpin – SIM Project Management Team

Bruce Decker and Denina Bautti-Cascio with Collective Impact facilitated the meeting.

An overview of the meeting agenda and **expected meeting results** were reviewed as follows:

- Define the context and characteristics of "High Value/Super-Utilizer" subpopulations
- Operationalize the definition of a "High Value/Super-Utilizer"—how the definition will work in practice
- Determine what data are needed and where these are located to begin developing programs or to scale up demonstrations to address the needs of "High Value/Super-Utilizers"
- Develop approaches/ways to meaningfully exchange and share data between provider and payor and vice versa

Collective Impact reviewed the following **virtual meeting ground rules** with participants:

- Log on 10 minutes before the start of the meeting since some online products require downloads and installation.
- Refrain from discussions related to any pending or prospective procurement of services or goods.
- Do not engage in discussions or agreements that have anti-competitive objectives or results (e.g., pricing, territories, etc.).
- State your name when you speak … every time! Try to speak one at a time so that everyone can pick up the conversation in its entirety.
- Limit your responses to no more than 30 seconds for each response to give others a chance to comment—be concise and don't beat the "dead horse."
- Stay focused and on task (use of parking lot).
- Be aware of background noise. Don't put the conference call on hold. If you leave the call to answer another line or talk to someone in your office, the hold music will play and disrupt our meeting.

- Be responsible for your full participation and stay focused during the meeting. Please do not multi-task (e.g., emails, calls, other work, restroom, cooking, etc.).
- Be positive and solution oriented—don't be critical, rather "build up" on what is being said to make it better.
- We will be using "roll-call consensus"—simply state thumbs up, thumbs to the side or thumbs down.

    - Up – I support this idea.
    - To the side – I can live with it while it may not meet all of my needs, but I don't have strong reservations about the decision.
    - Down – I cannot support this decision and have concerns and a solution that the full team must hear before we move forward.

December Task Force Meeting Review and Update

Joshua Austin, SIM Project Coordinator, provided a PowerPoint presentation highlighting the outcomes of the December Task Force meeting and providing an overview of future sessions. Suggestions from participants regarding the presentation follow:

- It would be good to know "unique" cases on slide #5. That is, patients who might be super-utilizers for legitimate reasons versus those who are not.
- Add CAMC as a partner on slide #6.
- Unduplicated patients should be captured on slide #9. This request can be made to Truven Health Analytics via Jeff Wiseman.

NOTE: meeting notes were taken by Joshua Austin, David Campbell and the Collective Impact team. Every effort has been made to ensure accuracy. If you notice a factual error or misstatement, please contact Joshua Austin at jaustin3@hsc.wvu.edu or via phone at (304) 400-8300 to make a correction.

Definition of "High Value/Super-Utilizer" Subpopulations—Decision Point 1: How do you define "High Value/Super-Utilizer" subpopulations (context and characteristics)?

- WVUHS: Study conducted in December 2015 with Medicaid and Medicare recipients.

    - Six thousand six hundred (6,600) patients—defined "high-utilizers" as ED use greater than 10 times in one year, hospitalization more than four (4) times in one year and primary care medical home more than six (6) visits in one year.
    - Four hundred three (403) patients fit into the high-utilizer category.
    - Two hundred forty-two (242) of those 403 patients had psychiatric diagnosis.

- Most frequent users of health care services were those patients with one medical condition and a psychiatric diagnosis.
- Twenty (20) – 25 age range (highest) 50-64 age range (next highest) represented the majority of high-utilizer clients.
- The study produced no data on costs of care, but costs savings are inferred.

- What are the most frequent diagnoses? Mostly Axis 1 diagnoses: all psychological diagnostic categories except mental retardation and personality disorder.
- Coding for ED visits often does not list the Axis 2 diagnoses, which includes personality disorders and mental retardation, due to reimbursement challenges.
- The second most frequent diagnosis was substance abuse-related.
- The Task Force discussed developing a common definition of a super-utilizer. There was considerable debate about whether or not there should be a cost indicator or threshold focusing exclusively on patients in the upper 3-5% of health care costs. This was viewed as limiting flexibility of implementation among smaller institutions/hospitals, so this was not adopted.
- There was broad agreement that the definition should include social determinants of health and should be general in nature.
- Consensus (12 thumbs up, 4 thumbs to the side and 0 thumbs down) on the following definition:

> *Super-utilizers experience complex physical, behavioral and social determinants of health that are not well met through the current fragmented health care system. These individuals would receive better care at a lower cost if they were identified and provided coordinated care.*

NOTE: The term "experience" was used in place of "battle" (in red) and "could" was changed to "would" to appease SIM Task Force members who had minor issues with the definition's wording.

Operational Definition of "High Value/Super-Utilizer" Subpopulations—Decision Point 2: Next, we must operationalize our definition of super-utilizer. How will this definition work in practice? Most operationalizations use ED visits and/or hospitalizations as a starting point. One major point to keep in mind is that we should be encompassing enough to incorporate a sufficient population to actually make an impact on costs and quality.

- There is a difference between frequent and high-utilizers; the Medicaid Complex Care Program definition is an example.
- Three part signal of high utilization: 1. number of ED visits, 2. multiple hospitalizations and 3. costs.

  - Perhaps spending too much time and focus on part 3, costs—there is a broader outcome: moving from illness/acute care to actual health care and improving overall health. The Task Force could be looking at this from a perspective of quality of life and not just costs and visits. That is, other types of operationalizations have merit, too.

- A related consequence of high ED utilization is that patients are not receive the right type of care. There could be better care received at the PCP or PCMH level.

  - One thousand two hundred (1,200) SSI patients in three FQHCs with Partners In Health Network were included in pilots to address diabetes, congestive heart failure and polypharmacy to address quality and cost issues.
  - "Triple Arrow for the Triple Aim:" project demonstrated that a modest investment in care coordination and clinical pharmacy review can produce significant reductions in hospitalizations and harmful polypharmacy for community dwelling dual eligibles. Cost savings are inferred from this approach, but no specific ROI has been provided. Article published in the *Journal of Primary Care & Community Health* in November 2015: http://jpc.sagepub.com/content/early/2015/11/17/2150131915617297.full.pdf?ijkey=JubUCsn15lOofdh&keytype=finite.

- Pay now versus pay later perspective. Either we take action (pay) now or pay even more later on.
- Best option for these super-utilizers is for them to be seen (a.k.a. "eye-balled"). Is there a human capacity for follow up and interaction? Data points helps us to identify these individuals on the frontend.
- Super-utilizers can be tracked using a number of EHR and HIE-integrated programs, including the EDIE Project, CAPGATE (proprietary system of Partners In Health Network) and MMIS.
- Operationalizations presented in the meeting discussion document are based on a claims look back. This can help to identify one tier of the super-utilizer population, and it can help to identify previous super-utilizers. However, there is a larger population beneath that surface—those at high-risk of becoming super-utilizers. That is where predictive modeling and using social needs/determinants is needed to prevent that transition to the super-utilizer status.
- Perhaps the Task Force should look at "tiers" or "levels" of high-utilizers, such as those posited below:

  - Super-utilizers – look at utilization such as costs, ED visits, hospitalization visits, etc.;
  - Frequent utilizers – those parents who are at high risk of becoming a super-utilizer – looking at claims data, social service needs data, etc., and using interventions to prevent individuals from moving into super-utilizer status
  - Exclusion group – patients seen in the ED frequently, but may not be there inappropriately.

- Related to the above tiers or levels posited: Can we develop enough commonality of definition, so each group can find an intervention for a subpopulation? That is, historic versus predictive modeling for high claims.
- The Task Force requested a Tiger Team/Subgroup to further identify the operational definition/criteria and tiers/levels of high-utilizers before the next meeting. This request was met with consensus (16 thumbs up, 1 thumb to the side and 0 thumbs down). Proposed Super-Utilizer TIGER Team/Subgroup members follow:

- Christopher Colenda, M.D., WVUHS
- Karen Fitzpatrick, M.D., WVUHS
- Barbara McKee, Partners In Health Network
- Karen Yost, Prestera Center
- Craig Robinson, Cabin Creek Health Systems
- Vicky Gallaher, UniCare (Mitch Collins)
- CoventryCares TBD (Todd White)
- Highmark BCBS TBD (Fred Earley)
- Jon Cain, WV Bureau for Medical Services

Decision Point 3: We have defined what a super-utilizer is and operationalized that definition. Now, what data are needed and who/what entities have the data we need to begin developing programs or to scale up demonstrations to address the needs for this population?

- There is an intersection of high-quality, scrubbed claims data to first identify these super-utilizers—coupling that with socio-economic aspects. Claims data would be with the insurance payors and government. Non-claims related data are needed, such as survey data, socio-economic data, etc.
- "Real time" data is essential—predictive data is preferred.
- Information on ED visits, polypharmacy would be helpful.
- The Task Force should reach out to see what data points are being collected by current or former pilots/demonstration projects. Examples: Dr. Christopher Beckett at Williamson Health and Wellness Center, Dr. Sarah Chouinard at Community Care of WV and Craig Robinson at Cabin Creek Health Systems—to name but a few.
- Prestera Center has information about the current Medicaid Health Home (e.g., Bi-Polar and Hepatitis B/C) and other pilots/demonstrations.

Decision Point 4: What resources will be needed to analyze and meaningfully interpret these data?

- Multi-stage process, including a screen that sets the definition of a super-utilizer, operationalizes that definition and gathers the associated data. That data is then, hopefully, provided to a human, such as a PCP or a care coordinator, for appropriate intervention or follow up and triage.
- These systems will require sophisticated biostatisticians and data analysts. West Virginia needs individuals who can help providers/payors meaningfully utilize these data and make decisions.

Decision Point 5: How can/should these data be shared among payors, providers and governmental agencies?

- Partners In Health Network multi-visit patients average 30 or more health care encounters in a year and 12 or more ED visits. The population is also transient. Using claims to develop interventions would be too late for this population.
- Real-time care alerting is vital for follow up and devising super-utilizer intervention strategies. There are a few systems that do this in West Virginia now, including the WVHIN, CAPGATE and EDIE Project (e.g., ED specific care alerting).
- Among networks of providers who are working together to address the super-utilizer population, it is important to have real-time ED and hospitalization information.
- One key challenge is to blend disparate claims, clinical and socio-economic patient data; the Veterans Administration already shares data effectively across behavioral health and primary care providers.
- The WVHIN is developing care alerting infrastructure. It is piloting this in Huntington with Cabell Huntington Hospital, Marshall University Health / Highmark BCBS. Other providers are being primed to participate at this time, and in various locations. This should be operational the first week of February 2016.
- From Prestera Center's perspective, real-time care alerting would be invaluable; its providers find out about ED visits or admissions after the fact (usually only if the patient tells the Prestera Center provider about it or if a case worker at a hospital meets the patient at ED/admission).
- EDIE (Emergency Department is for Emergencies) Project, an initiative being led by the West Virginia Hospital Association, is a mini-HIE for emergency departments.
- The Medicaid Complex Care Program is a conduit to provide claims data to participating providers/organizations. Currently CAMC, Partners In Health Network, Marshall University Health and WVUHS have signed MOUs to receive these data from Medicaid.

Decision Point 6: How will care teams and/or community health support resources access, use, enhance and share these data?

- Privacy issues can be challenging—maybe include in health plans the client's authorization to release information to pertinent entities.
- HIPAA and HITECH Act data sharing guideline complicate sharing of information/data among care team members. There has been some success in enrolling patients into a particular plan upon enrollment. The patient must play a key role in this decision; it is vital to respect and inform him/her of the right to privacy.
- In terms of a care team, the super-utilizer population is lacking a PCMH or even a PCP. How would we connect these individuals to a PCMH or even a PCP? What do the payors think about this (a.k.a. "Gatekeeper" model)? Who can tell the patient where they can access care?
- High-utilizers typically do not have a "team" or medical home—it is important to ask them to select one or assign them to one, but we must be mindful of federal requirements regarding mandated service provision.

- PEIA has the advantage of leveraging members into a PCP/pharmacy relationship.
- UniCare finds that when a member is connected with a PCP, their compliance and satisfaction is much higher. However, UniCare does encounter members who struggle to understand the system. MCOs could utilize care management system(s) to better connect members with a PCP and educate members about how to appropriately access care.

Next Steps and Wrap Up

- The next Task Force meeting is tentatively scheduled from Monday, February 29, 2016; it will likely be a webinar/electronic meeting.
- Four (4) participants commented that they generally liked the webinar format.
- Is there a way for SIM to document models/pilots/demonstrations that have worked? Can we discuss this at a future meeting? Several pilots/demonstrations have been tried in the state and may be ready to be scaled up.
- Can we development a framework for innovation and model patient improvement? Several pilots exist: how do we set up a process to take to successful innovations to scale?

Task Force Meeting Notes Submitted by: Bruce Decker and Denina Bautti-Cascio, January 26, 2016
Task Force Meeting Notes Revised by: Joshua Austin, February 2, 2016